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ABSTRACT

A review of the literature and personal interviews with mental health administrators and other informed persons revealed that multiple inservice and preservice educational needs exist among administrators serving the aged in hospitals, nursing homes and other care facilities, mental health centers, and mental health associations. Specific educational needs discovered by the survey were categorized and translated into a list of learning objectives for administrators serving the aged in the field of mental health and related areas. These objectives relate to the following areas: management and records, problem resolution, projection of needs, education of the public and the aged, and outreach and philosophy. Community colleges and universities should discuss these educational needs and develop ways of meeting them. Inservice programs from continuing education departments could reach administrators already employed. However, the expanding need forecast by the expanding population of the elderly might better be served by establishment of master's programs in mental health administration with emphasis in geriatrics or a Master's of Public Health with a specialty in gerontology. (KC)

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EDUCATIONAL NEEDS OF MENTAL HEALTH ADMINISTRATORS SERVING THE AGED

By Connie Tindell

Education for professionals working with older adults is emerging as a need across the nation, especially in those states with heavy concentrations of persons over sixty. North Carolina is one of those states, with nearly thirteen percent of its population aged 60 or older, one-third of whom live in poverty, and one out of five of whom lives alone (Hunt, 1977). Trends indicate that the proportion of older adults will continue to grow throughout this century, reaching nearly twenty percent by the year 2030.

Concerned with the mental health of this large group of citizens, Governor Hunt of North Carolina called a Conference on Mental Health in March 1979. Task Forces were assigned to examine needs of various segments of the population. As a member of the Task Force on Older Adults, the author was asked to survey educational needs of administrators serving the aged in mental health and related areas.

A cursory review of the literature and personal interviews with mental health administrators and other informed persons revealed that multiple in-service and pre-service educational needs exist among administrators serving the aged in hospitals, nursing homes and other care facilities, Mental Health Centers, and Mental Health Associations (Creech et al., Note 1; Easterling, Note 2; Ensley, Note 3; Jain, Note 4). Needs common to most administrators in other fields were found. Such needs were in the areas of fund-

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ing, budgeting, recruiting, organizational structure, communication, etc. Though these requirements are not to be minimized, education for them is readily available. The needs more difficult to meet are those specific to the combination of mental health and aging. A few of these specific needs will be discussed briefly, and a more comprehensive list in the form of suggested educational objectives will be given at the close of this article.

The literature revealed that in the State of New York Bissonette and Zusman (1976) found two areas of greatest need for middle managers in community mental health service to be:

1. Knowledge of clinical procedures sufficient to appreciate and evaluate activities of direct service workers.

2. Skill in coordinating resources as opposed to providing or allocating them.

A check of the list of suggested educational objectives will show that these needs were prominent in North Carolina as well.

According to a State of North Carolina Health Facility Consultant (Note 5), educational needs of nursing home administrators fall into two broad categories:

1. Information sharing among professional staff.

2. Use of patients' medical records for problem resolution rather than crisis management.

Reluctance of the nursing staff to share their observations with nutritionists leads to treatment of digestive disturbances with medication when a better solution might be a change in diet. Nutritional deficiencies (as well as loss of hearing or multiple physical illnesses afflicting the aged) are known to produce symptoms analagous to mental illness.

Suggested tools for problem resolution rather than crisis management are quarterly review of records, random sampling techniques with follow-up, and use of peer review for nurses, social workers and administrators. These activities presuppose that the administrator has an adequate knowledge of medical terminology, rehabilitation potential, and the use of interdisciplinary conferences.

Epstein (1978) explains that mental health could be much improved by seeing that the aged receive routine, regular, comprehensive medical and dental care to improve their physical health. In addition, the general lifestyle of the aged has great impact on mental health. The administrator should be aware of the key ingredients of a healthy lifestyle: socialization, proper nutrition, good daily habits, exercise, and maximum independence.

Maximum independence is the goal of progressive patient care in which several levels of care are provided, each less restrictive than the next, with the option of remaining at home being the least restrictive. "Living dangerously with independence is sometimes better than being cocooned in an institution" (Brocklehurst, 1977, p. 235). However, negative public attitude toward community treatment for the mentally ill or problem drinkers must be overcome for the goal of maximum independence to be realized. Thus the administrator must be a public educator.

An important aspect of community treatment is human contact, especially for many of the aged who live alone. Personal contact can be assured by coordinating available human resources found in local clubs and agencies and through the creative management of volunteers. Such creative management might include the

formation of a volunteer career ladder with the administrator screening applicants, hiring, training, promoting or demoting the volunteer workers (Easterling, Note 2). Because the mental health of all ages is improved when a balance is obtained among work, recreation, and service to other, the aged themselves, as well as the middle-aged and the young should be recruited for volunteer service. Placement should be made in accordance with individual needs of the worker and of the persons to be helped.

Continued learning is of great value to older minds; it helps prevent deterioration of the brain. Administrators should be aware of the benefits of engaging older persons in all the thought processes, not only acquisition of knowledge, but also its application, creative problem solving, and synthesis (Easterling, Note 2).

Specific educational needs revealed by this survey have been translated into a list of learning objectives for administrators serving the aged in the field of mental health and related areas. The suggested objectives are categorized and presented below.

Suggested Educational Objectives

Mental Health Administrators serving the aged will be able to:

Management and Records

1. Determine acceptable standards of care in various treatment modalities.

2. Use patient care records for improved quality of care, for staff training and supervision, and for program management.

3. Measure patient care as an output.

4. Read and understand medical terminology.

5. Ensure sharing of information among professionals within an institution (nurses, nutritionists, social workers, etc.).

Problem Resolution

1. Use quarterly review of records as a tool for problem resolution.

2. Coordinate with ancillary support systems within and outside the organization.

3. Use progressive patient care--patient movement to most appropriate level of care available through frequent need assessment, strong referral linkages, and adequate resources. Ensure maximum patient independence and well-being.

4. Provide preventive mental health care for aged in the area.

5. Furnish follow-up and pre-release consultation with the aged being released from institutions.

6. Apply random sampling techniques and follow-ups.

7. Use peer review for nurses, social workers and administrators.

Projection of Needs

1. Predict the "at risk" population figures.

2. Project need for beds and family care services.

3. Compute cost analysis of treatment.

Education

1. Plan public education programs to reduce negative

attitudes toward the aged, the mentally ill, problem drinkers, and community treatment and rehabilitation.

2. Encourage public participation in delivery of services to the aging.

3. Plan education for older developmentally disabled in nursing homes and staff training for those working with developmentally disabled.

4. Give mini-lectures to groups of older citizens on common sense things such as: What to do when depressed; How to volunteer services.

5. Plan for creative learning for older minds.

Outreach and Philosophy

1. Creatively manage volunteers.

2. Stimulate outreach for personal contact with older persons through existing agencies and clubs, realizing human contact is essential.

3. Avoid value imposition upon patients or clients.

4. Treat older adults realistically, avoiding overprotection.

5. Emphasize positive aspects of growing old, while being aware of physiological, psychological, and sociological changes.

6. Engage in direct service occasionally to keep in touch with the aged.

7. Develop a frame of reference for mental health rather than mental illness.

How will this vast amount of education be furnished? This is a question which decision-makers in community colleges and the

university system must address. In-service programs from Continuing Education could reach administrators already employed. However, the expanding need forecast by the rapid growth of the aged population might better be served by a Master's program in Mental Health Administration with emphasis in geriatrics (Ensley, Note 3) or a Master's of Public Health with a speciality in gerontology (Jain, Note 4).

Perhaps the greatest need is for public education to correct negative attitudes about the aged. Alex Comfort (1977) asserts that "the time has come to stop treating old people as a problem and begin treating them as people" (p. 30). And Robert Butler (1977) reminds us that "when we talk about older people we are not talking about 'them' or 'they,' but we are talking about all of us, now or in the future" (p. 34).

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